Periscope

Miscellany

THE GRADUAL CURE OF HYSTERICAL PARALYSIS. H. T. Pershing (Journal A. M. A., May 11).

The sudden cure by suggestion or otherwise, of hysterical paralyses, however practicable and tempting in cases in which one can be sure of the diagnosis and of his power to impress the patient, is not the one to be generally chosen. Failure may compromise future success, and too prompt success may have its disadvantages in depriving the patient of the discipline and enlightenment that are necessary to a permanent cure. The safer way is more gradually to arouse and exercise the dormant kinesthetic centers, overwhelmed by inhibitory impulses from other centers, due to the perverted emotional conditions and ideas, by first raising the emotional tone, encouraging the patients to believe they will recover, and if such cheering is opposed or resented, appealing to their *amour propre* by judicious suggestions. The physical measures—rest, food, tonics and sedatives—while of great importance, are sometimes overvalued, he thinks, but both mental and physical treatment should be employed in these cases in harmonious combination. While doing this, the dormant kinesthetic centers can be acted on specifically by sensory stimulation. Hysterical anesthesia is not absolute and strong faradic currents, applied to the skin and muscles, followed by vigorous and even rude, passive motion of the affected limb, have a powerful tendency to restore the lacking sensations and ideas of motion. The patient's close attention should be directed to the anesthetic part and every slight beginning of sensation noted. This will tend to bring the cortical sensory centers again into relation with the other centers in the cortex. After awakening some degree of normal sensibility and overcoming inhibitory fears, the cure can be completed by exercise in voluntary motion. If the paralysis is nearly total it is as well to let the first attempts be favored by gravity, which will assure some motion and encourage the patient to increase it. A beginning once made, the attempts can be gradually increased, every encouragement being given, till at length some normal control is obtained, and the patient is able to practice some assigned exercises in the physician's absence. The length of time taken in accomplishing the cure may be made an advantage by using it to carry on a re-education in composure and self-reliance, without which permanent recovery is impossible. Two cases of typical hysterical paralysis are briefly described in which this method had been employed with complete success.

SYRINGOMYELIA, EXTENDING FROM THE SACRAL REGION OF THE SPINAL CORD THROUGH THE MEDULLA OBLONGATA, RIGHT SIDE OF THE PONS AND RIGHT CEREBRAL PEDUNCLE TO THE UPPER PART OF THE RIGHT INTERNAL CAPSULE (SYRINGOBULBIA). William G. Spiller, M.D. (British Medical Journal, Oct. 20, 1906).

The interesting features in this case are found in the pathological study.

The extent of the cavity is greater than any heretofore described, and in fact has even been regarded as impossible. The patient's first symptom was a weakness in the left foot developing when he was seventeen years old, which progressed slowly until, in six years, the whole left side was paralyzed. The right side then became gradually weaker, and four years later he was completely helpless. Examination showed atrophy of the right side of the tongue with a marked impairment of the sense of taste, especially on that side. There was great impairment of motion in the arms, especially in the right. There was considerable wasting of the arms more marked in the distal portions. The right leg also was more affected than the left, and was 2½ inches shorter. Sensation for touch was felt normally throughout the body, but for pain and thermal sensation the disturbance was pronounced. The patellar jerk was exaggerated on the right side and diminished on the left. Death was due to bronchopneumonia. The cavity in the spinal cord began in the lower sacral region in the left posterior horn to which it was still confined in the upper sacral and lumbar region. From the midthoracic region upward the spinal cord was distorted and flattened. In the medulla there were distinct cavities in each anterior pyramid; the one on the right side being larger and cutting off the fibers of the hypoglossal nerve on that side. In the upper part of the medulla the cavity in the left anterior pyramid had disappeared. In the pons; the cavity in the right side extended nearly to the raphe. The right adducens fibers were degenerated. In the right cerebral peduncle the cavity was a narrow slit in the substantia nigra and extended into the upper part of the crusta near the median side of the peduncle. In the lower part of the internal capsule the cavity divided; one part soon terminated, but the other extended upward to within two or three millimetres of the lower surface of the lateral ventricle, but did not open into the ventricle. Schlesinger, in his monograph, says that in syringobulbia the cavity does not extend above the fifth nerve and involvement of the first four cranial nerves indicates a complicating lesion. This case shows that the third, fourth, or fifth cranial nerves might be involved by a cavity and that symptoms in the distribution of these nerves need not necessarily imply a complicating lesion. The atrophy of the right side of the tongue is explained by the complete degeneration of the hypoglossal nerve and its nucleus. C. D. CAMP (Philadelphia).

DISLOCATION OF VERTEBRÆ IN LOWER CERVICAL REGION. William C. Krauss Annal. of Surg., November, 1906).

In connection with a review of the literature on this subject, Dr. Krauss reports an interesting case of dislocation of vertebræ in the lower cervical region, followed by symptoms of complete severance of the spinal cord. Laminectomy was performed with a result of partial restoration of function later. The report is in brief: Male, 22, healthy, dived into shallow water, became semi-conscious and devoid of power in arms and legs. On admission to hospital there existed total paralysis of legs; arms and hands partially paralyzed. Speech, eyes, pupils and facial muscles not affected. Head slightly retracted, but moves in all directions with some pain. Tenderness over spinous process of the fifth cervical vertebra, and indefinite pain about third thoracic spine. Pulse slow, full, and good tension. Heart normal, respiration diaphragmatic, no temperature. Patellar, ankle and plantar reflexes absent. Marked priapism. Patient able to flex arms, but not to extend them. Movements of fingers and